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Joint Commission RESOURCES

Joint Commission:
The SOURCE
Accreditation Compliance Strategies for Operational Improvement

Shared Visions—New Pathways: Learn What's in Store for Your Organization

The new accreditation process will progressively sharpen the focus on care systems critical to the safety and quality of care.

Many health care professionals are talking about the Joint Commission's new accreditation process, Shared Visions—New Pathways, which is scheduled for implementation in January 2004. Organizations already have been informed about the new components of the accreditation process (see *Joint Commission Perspectives* October 2002 available *free* online at www.jcrinc.com/periodicals), but they also want to know how Shared Visions—New Pathways will affect them, and how they can prepare for it.

Shared Visions—New Pathways shifts the paradigm of the current accreditation process from a focus on preparing for the "exam" and getting a score to continuously using the standards as a means to achieve and maintain excellent operational systems. Table 1 on page 10 highlights how these components will roll out.

In this report we'll focus on four components of the initiative—revised standards, organization self-assessment, priority focus process, and new survey process—and explain how each impacts your organization.

Enhancing the Relevance of Standards

To ensure that standards focus on critical patient safety and health care quality issues, JCAHO has been intensely reviewing standards for more than two years. The modifications are mostly deletions, consolidations, and clarifications of existing standards. In fact, the number of standards decreased between 25% and 60% (depending on the accreditation program) for the six functional chapters* that have passed through JCAHO's review and approval process thus far. The number of scoreable elements similarly decreased between 30% and 45%. This reduction in redundancy and improvement in clarity results in significant reduction of the clinical documentation burden, especially for nursing staff that traditionally manage the patient care documentation.

Making Self-assessment Part of the Process

Most organizations already have some process in place to assess and attest to their own compliance with JCAHO standards. A formalized self-assessment, using a Web-based program on JCAHO's secure extranet site, will provide an in-depth tool

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** The standards chapters approved by JCAHO's Board of Commissioners in December 2002 include Environment of Care; Ethics, Rights, and Responsibilities; Improving Organization Performance; Leadership; Management of Human Resources; and Nursing.*

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To Our Readers

Welcome to the premiere issue of *Joint Commission: The Source*, the authority on timely, complete, and correct information on complying with key JCAHO initiatives, standards, and policies and procedures. Each month *The Source* will share expert, practical, "how-to" information to help you consistently meet JCAHO requirements. Performance improvement directors like yourself—in ambulatory care, assisted living, behavioral health care, critical access hospital, health care network, home care, hospital, laboratory, and long term care settings—can count on *The Source* to

- help you implement current and new JCAHO standards and initiatives;
- provide practical and necessary information on how to successfully prepare for surveys, as well as maintain continuous survey readiness;
- share sample forms, educational tools, case studies, and strategies for assessing staff competence and performance;
- keep you up-to-date about Shared Visions—New Pathways; and
- supply answers to your most frequently asked questions.

We hope *The Source* will become *your source* for clear, concise information on how to achieve continuous performance improvement and excellence in quality of care.

We want to know which topics you'd like to see covered in future issues. Please e-mail your comments and questions to **thesource@jcrinc.com.**

Shared Visions—New Pathways

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that significantly reduces the need to "ramp up" right before survey. Ambulatory care, behavioral health care, home care, hospital and long term care settings will complete the self-assessment in 2004.

Organizations scheduled for survey in July 2005 and after will begin receiving their self-assessment tool in the fourth quarter of 2003. They will begin transmitting their self-assessment results and any Corrective Action Plans to JCAHO in January 2004 and after. Although organizations scheduled for survey before July 2005 won't be required to submit the self-assessment, they will have access to a demo version to familiarize them with the self-assessment tool.

At the 18-month point in a three-year accreditation cycle, organizations will assess their level of compliance with *all* applicable standards and plan corrective actions for any compliance issues. There will be no on-site survey at the 18-month point.

Together with ongoing ORYX data collection and random unannounced surveys, the self-assessment truly makes accreditation a continuous process, not just a single event in time.

The self-assessment positively impacts organizations by providing an educational benefit through involvement in their own system analysis, and the automation of the tool also substantially minimizes the work burden of such an assessment.

If organizations find in the self-assessment that they are not compliant in any standards area, they must provide a detailed Corrective Action Plan to JCAHO on how they have complied or will comply with the standard(s). A JCAHO Standards Interpretation Group staff member will follow up with a phone call to review findings, approve Corrective Action Plan(s), and provide advice or assistance on those actions. The self-assessment findings and plan of correction will not change the current accreditation status. Surveyors will validate implementation of corrective actions during the triennial on-site survey.

Focusing on Critical Processes

A new Priority Focus Process (PFP) establishes the survey agenda, based on pre-survey information, to focus on areas that are significant to an organization's patient safety and quality processes.

An automated priority focus tool (PFT) gathers pre-survey data from the health care organization using JCAHO sources (ORYX data, self-assessment, previous recommendations, electronic application) and external sources (average length of stay, mortality rate, MedPar/CMS). Using automated sets of rules, the tool sorts the data and directs the on-site survey to critical areas of focus. The identified systems, structures, and processes are determined to be relevant to that organization's patient safety and quality of care. The process does not

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Accreditation Essentials

Strategies for Meeting New JCAHO Requirements

JCAHO implemented new and revised standards on the safety of individuals served for *behavioral health care* and *long term care organizations* on January 1, 2003.

Behavioral health care and long term health care organizations are not alone in their efforts to promote a culture of safety. Likewise, each of the 18,000 organizations accredited by JCAHO will be evaluated for compliance with the 2003 National Patient Safety Goals and Recommendations, or implementation of acceptable alternative strategies, as appropriate to the care they provide.

This article offers practical tips on how to comply with new or revised standards, as well as how to apply selected patient safety goals.

Rights

One of the goals of the rights function is to help improve outcomes by respecting each individual's rights. One new standard in the rights chapter (**RI.1.2** in long term care and **RI.1.2.7** in behavioral health care) addresses the right of individuals served and their families to be informed about the outcomes of care. This standard is applicable to all long term care facilities and the following types of behavioral health care organizations: crisis stabilization, residential, partial hospitalization, supervised/transitional living, 24-hour corrections, and 24-hour forensics.

The intent states that the responsible licensed independent practitioner or his or her designee informs the individual about the unanticipated outcomes, at a minimum those related to sentinel events considered reviewable by JCAHO.

> *"Leaders are responsible for creating and fostering such a culture through personal example and by making safety and proactive error reduction priorities."*

TIP As you develop ways to communicate outcomes to the individuals in your organization's care, you may want to consider adopting some of the strategies implemented by a coalition of health care organizations in Minnesota.[1] (Note: These are not JCAHO requirements, and not all strategies are appropriate for all organizations.)

- Have the practitioner inform appropriate administrative personnel before discussing outcomes related to a medical accident with the care recipient. Mentoring the practitioner on how to handle the discussion, reviewing what should be discussed, and initiating risk management and quality assurance functions may be required.
- Have a second individual present during the initial conversation with the care recipient to assist with documentation of the conversation and to provide continuity and clarity.
- In rare instances where disclosure of an event will have a harmful effect on the care recipient's well-being, withhold disclosure until such time that the benefits of disclosure are greater than the harm.
- Give care recipients and their families the option of having another person with them for support during complex or difficult discussions.
- During initial and follow-up discussions, express the organization's and staff's regret and apology for the unanticipated event. Among other topics, you may want to provide information on the known, definite consequences and potential consequences of the event for the care recipient, actions taken to treat or ameliorate the consequences of the event, and who will manage the care recipient's ongoing care.
- Record the facts and pertinent points of the conversation in the clinical record.

Leadership

The introduction to the safety and error reduction standards describes the importance of a culture of safety and an integrated and coordinated approach to the improvement of safety and error reduction. Leaders are responsible for creating and fostering such a culture through personal example and by making safety and proactive error reduction priorities.

TIP How is this accomplished? Julianne M. Morath, chief operating officer and chief nursing officer of Children's Hospitals and Clinics in Minneapolis and St. Paul, provides an example of such leadership. Winner of the 2002 John M. Eisenberg Patient Safety Award for Individual Lifetime Achievement, Morath maintains steady focus on raising the bar on safety by addressing patient safety as the foundational issue in health care delivery. She offers the following advice to other

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Note: Not all the standards will be applicable to all the diverse settings in behavioral health care. Applicability is determined by the comprehensiveness of the treatment, care, or services organizations provide and the amount and type of risk or control for which the organization is responsible.

Meeting JCAHO Requirements

Continued from Page 3

leaders interested in establishing a culture of safety:[2]

- Accept personal responsibility for patient safety as your job.
- Declare that patient safety is urgent and a priority.
- Believe that harm-free care is possible. Start with a personal and passionate belief and commitment for action, asking if this is a safe place to give and receive care.
- Identify and develop champions throughout the organization and medical staff.
- Personally invest in learning about patient safety, and become involved in analyzing events.
- Import new knowledge and skills from other sciences and industry.
- Start with understanding the organizational culture and patient safety experience and use that data as a platform for change.
- Be visible.
- Focus on language and blameless reporting.
- Remove barriers to safety through fair and timely management of intentional violations, disruptive behavior, malfeasance, felony, impairment, and failure to learn over time.

A new standard (**LD.6.1** for long term care and **LD.5.2** for behavioral health care) addresses the leadership role in ensuring the definition and implementation of an ongoing, proactive program for identifying safety risks to individuals served and reducing medical or health care errors. This standard is applicable to all long term care facilities and the following types of behavioral health organizations: crisis stabilization, residential, partial hospitalization, supervised/transitional living, 24-hour corrections, 24-hour forensics, and case management. Organizations are required to select at least one high-risk process each year for proactive risk assessment.

In theory, almost any health care process or subprocess could benefit from proactive analysis. In practice, however, health care organizations have limited time and resources to use failure mode and effects analysis (FMEA) or other proactive techniques with processes occurring within the organization.

TIP So where should leaders focus their attention?

- Identify processes in which a failure of some type is most likely to jeopardize the safety of the individuals served by the organization. These are high-risk processes. Use internal performance improvement data; customer feedback; data from sister, parent, or similar organizations on a local or national level; association, society, and professional literature; and issues of the Joint Commission's *Sentinel Event Alerts* to identify such processes.
- Select for proactive analysis the process(es) most likely to have an adverse impact on the safety of individuals served, either because of high volume or interrelatedness to other processes.
- Start with a small and manageable process or piece of a process.

Information on how the safety and error reductions standards will be implemented in other settings can be found in Table 1.

2003 National Patient Safety Goals

In addition to the focus on safety in the new and revised standards, JCAHO also has identified six topics and 11 corresponding recommendations as part of its 2003 National Patient Safety Goals for all accredited organizations. The goals and recommendations cover patient identification, communication, high-alert medications, wrong-site surgery, infusion pumps, and clinical alarm systems.

On January 1, 2003, JCAHO began surveying organizations for compliance with the recommendations, as relevant to the care they provide. Organizations are responsible for implementing the applicable recommendations or alternative approaches accepted by JCAHO.

Failure to implement the recommendation or an acceptable alternative during a full accreditation survey or a random unannounced survey will result in a special type I recommendation.

For more information about the National Patient Safety Goals, see the January 2003 issue of *Joint Commission Perspectives on Patient Safety,* available *free* online at www.jcrinc.com/periodicals. The Source

References

1. *Communicating Outcomes to Patients.* Brochure. St. Paul: Minnesota Hospital and Healthcare Partnership, 2002.
2. 2002 John M. Eisenberg Patient Safety Award Winner: Julianne M. Morath. *Joint Commission Journal on Quality Improvement* 28:637–645, Dec 2002.

Table 1: Safety and Error Reduction Standards: Implementation by Setting

Ambulatory Care	Standards in development; planned effective date 2004
Behavioral Health Care	Effective January 1, 2003
Health Care Networks	Standards in development; planned effective date 2004
Home Care	Standards in development; planned effective date 2004
Hospital	Effective July 1, 2001
Laboratory Services	In review
Long Term Care	Effective January 1, 2003

Quality Coach

Using Radar Charts to Track Your Survey Readiness

Health care organizations that maintain a state of survey readiness reduce ramp-up costs, maintain ongoing performance improvement activities, and, most important, ensure a consistent level of care.

One effective tool for tracking your survey readiness is a radar chart, also known as a spider diagram. A radar chart lets you compare your organization or process both to ideal goals and to average performance. In essence, it's a pictorial method of benchmarking. A radar chart allows you to illustrate a vast amount of information in a simple, easy-to-read graphic. You can use a radar chart to compare your organization's state of survey readiness with the national average of JCAHO results *and* with your organization's accreditation goals. The resulting tool will give you a well-rounded picture of areas in which you excel, as well as areas in which you need improvement.

The example below illustrates 48 data points for 16 different performance report grid element areas, comparing the results of the organization's self-assessment with ideal performance and the national average. Presenting 48 data points in a way that would provide meaningful insight typically would be difficult. A radar chart, however, presents an immediate picture and, as such, is an ideal tool to share high-level results with leadership and staff alike.

How to create a radar chart[1]

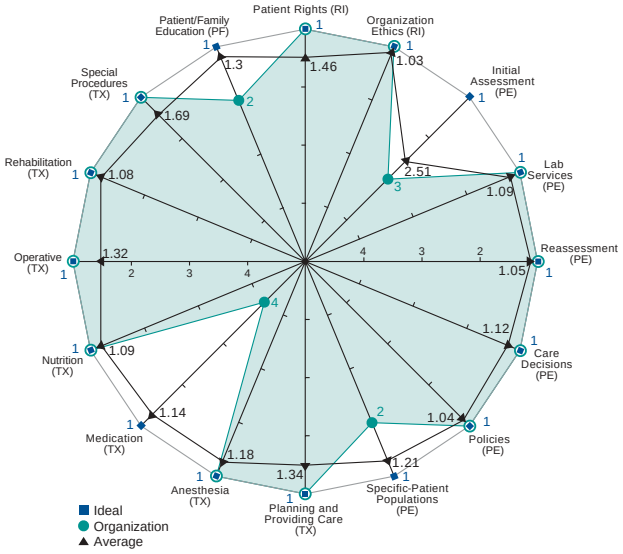
1. Identify the areas that you want to study. This organization chose to study its level of survey readiness. This radar chart illustrates the first four functional standards chapters.

2. Collect data on actual performance in these areas. The organization used its internal self-assessment results as the source material for actual data.

3. Benchmark performance in these areas; determine what is average performance for these areas. This organization referred to its most recent JCAHO performance report, which included national comparative data. (Performance Reports are available at www.jcaho.org, under Quality Check.) The organization converted the data in the report so that it corresponded to the radar chart scale by figuring out the average score for each grid element, similar to calculating a grade point average.

4. Identify your organization's ideal performance in these areas. This organization chose full compliance with all JCAHO requirements as its accreditation goal.

5. Create a rating scale for each area. This organization used JCAHO's accreditation scoring scale, with 1 being in full compliance and 5 being in noncompliance.



Survey-readiness Radar Chart

This radar chart depicts an organization's self-assessment results, national average, and ideal performance goals for the Rights and Ethics (RI); Assessment (PE); Care, Treatment, and Services (TX); and Education (PF) areas.

6. Rate your actual performance and plot it against the average and ideal performance. Each spoke will have an actual, an average, and an ideal quantity plotted.

7. Draw the chart. (Note: Many spreadsheet software packages allow you to create radar charts.) Begin by drawing a large wheel with a spoke for each area. Label each spoke. Plot your organization's performance for each level (actual, average, ideal) using a different color or shape for each level.

8. Connect the dots within each performance level (actual, average, ideal). Shade in the actual results area for maximum readability.

9. Identify the most significant areas where your actual performance fails to meet ideal performance goals. This organization needed to improve its performance in the initial assessment, specific patient populations, medication, and patient/family education standards areas.

10. Update your radar chart as your organization makes progress in meeting your quality goals so you maintain a current picture of your survey readiness levels. The Source

Note: As Shared Visions—New Pathways is implemented in 2004, organizations will not have access to actual scores for specific grid elements.

Reference

1. Joint Commission on Accreditation of Healthcare Organizations: *Tools for Performance Measurement in Health Care: A Quick Reference Guide.* Oakbrook Terrace, IL, Joint Commission Resources, 2002.

Addressing Frequently Cited Human Resources Standards

An essential focus of human resources (HR) is to ensure competent staff at all levels, but complying with certain HR standards has proved challenging for many organizations, as shown by standards compliance data. These challenging standards for all accredited organizations fall into three interconnected areas: staff orientation, staff competence, and data analysis.

Providing New Staff Orientation

Orientation is a core element of staff education and the starting point for continuing staff development. New staff must be oriented to the organization, to their specific department, and to their specific responsibilities. Orientation should be viewed as having two purposes: training new staff to do the job they were hired for and allowing the organization an opportunity to assess their abilities.

Organizations have received type I recommendations for not providing initial training, not providing adequate training, or not providing it in a timely manner.

TIP To address these problems, organizations should construct a plan defining the scope, length, and time frame of orientation programs, as well as the actions to be taken if an individual fails to perform adequately during the orientation period. To evaluate performance, some type of assessment tool is essential—for example, written tests or quizzes, role playing, or demonstrations. Moreover, the ideal orientation is tailored to a well-conceived job description that specifies what each new staff member needs to know. The job description also details qualifications such as required education, licenses, experience, skills, and physical/emotional capabilities.

Assessing Ongoing Staff Competence

Training and assessment do not end with orientation, however. Staff must continue to meet performance expectations whether they stay in the same position, take on new responsibilities within a position, or move into new positions within the organization. Job descriptions are essential to assessing competence, as they specify responsibilities, duties, and performance expectations in relation to the population served, including any special needs and behaviors of those persons.

Compliance problems occur if assessments are not performed on a timely basis or if organizations lack well-defined job descriptions and/or objective, measurable criteria for evaluating the described competencies and skills. Many organizations have difficulty designing measurable criteria, as well as matching them to each job description. In addition, assessment plans often fail to specify methods for correcting problems with individuals who do not perform satisfactorily on assessments.

> *"When organizations fail to comply with HR standards, the stakes are high and the potential consequences are serious."*

TIP To ensure quality and compliance with standards, organizations should develop assessment plans that define assessment frequency and ensure adherence to these time frames. They also should develop effective tools—for example, a combined job description/evaluation tool that easily allows organizations to document their assessment efforts and demonstrate which competencies are regularly evaluated.

Analyzing Data

Data can be used to compare an individual's competencies before and after orientation, to identify competence patterns and trends, to determine staff learning needs, and to evaluate education and training programs. Potential sources of data include performance evaluations, performance improvement efforts, risk management reports, patient satisfaction surveys, staff surveys, and competence assessment sheets.

Some organizations fall short on their use of data because they fail to track whether employees have undergone orientation and whether they have demonstrated competence. Other organizations do track the numbers trained and their test results, but they fail to aggregate and analyze the data for patterns. Thus, they miss opportunities to retool or refocus their training program in response to these patterns. Moreover, they fail to link staff performance on assessments to patient processes and outcomes.

TIP Organizations can improve their performance with regard to data use if they develop a plan that identifies the type of data that will be collected and how it will be gathered based on where the greatest risks lie and what is most important to the organization.

When organizations fail to comply with HR standards, the potential consequences are serious: inadequately trained staff members who lack competence and/or proper credentials and dissatisfaction and poor outcomes among individuals served. High-quality orientation, competence assessment, and data use significantly impact organizational performance by improving outcomes, safety, and satisfaction. TheSource

Asked and Answered

Be in the Know About Survey Process Changes in 2003

Q **What changes has JCAHO made to the 2003 survey process?**

A *The types of changes depend on the type of organization.*

Survey process changes for *all health care organizations*

- ***Compliance with National Patient Safety Goals and Recommendations.*** Organizations are required to demonstrate successful implementation of the recommendations, or acceptable alternatives, that are applicable to the care and services provided by the organizations for each of the six goals.
- ***Sentinel event policy.*** Organizations' response to *Sentinel Event Alert* recommendations will not be scored as part of the survey. For educational purposes, organizations will be assessed on their knowledge of *Sentinel Event Alert* recommendations and their plans to respond to them as applicable to the care and services they provide.
- ***Survey observers.*** Organizations are required to accept JCAHO surveyor management staff, surveyor preceptees, or Board of Commissioners members as observers on a survey.
- ***Online survey application.*** Via the extranet, a secure, password-protected environment, an organization can edit pre-populated information from its last application, answering only the questions that apply to its current services. Beginning in April 2003 organizations can expect to receive a packet containing a request for survey nine months before they are due for survey; paper applications will continue to be available as necessary.

Additional changes for *behavioral health care*

- ***Safety and error reduction.*** Surveyors will look for evidence that organizations are using a proactive risk assessment approach, such as a failure mode and effects analysis (FMEA), to enhance individuals' safety.

Additional changes for *hospitals*

- ***Patient Care Interview.*** This interview has been replaced by a Patient Safety and Medication Management Evaluation.
- ***Department Directors Interview.*** The Department Directors Interview will be eliminated and the additional time allocated to patient care setting visits.
- ***Environment of Care Interview, which includes a building tour and document review.*** The order of these two components will be switched so that the building tour follows the document review. The surveyor will use information gathered during the document review to assess areas during the building tour.
- ***ORYX Core Measures.*** Surveyors will evaluate how an organization has used the ORYX data collected for core measures.
- ***Staffing effectiveness.*** To demonstrate compliance with staffing effectiveness standards, hospitals should be able to provide surveyors with information about
  - rationale for indicator selection;
  - collection and review of screening indicator data;
  - response to variation from expected performance;
  - evaluation of the effectiveness of the response; and
  - whether this information is reported to leadership.

Additional changes for *laboratories*

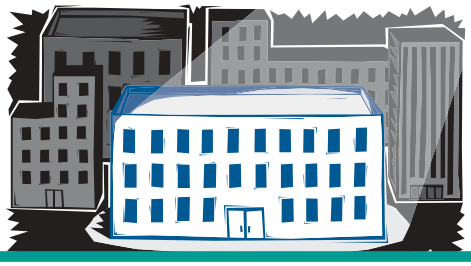
- ***Revisions to the scoring grid.*** The Single Function Lab terminology and separate scoring grid will be eliminated, so all laboratory services accredited by JCAHO will be scored under the same grid. The report text will designate which laboratory service location received a recommendation for improvement.

Additional changes for *long term care*

- ***Safety and error reduction.*** Surveyors will be looking for evidence that organizations are using a proactive risk assessment approach, such as FMEA, to enhance resident safety.
- ***Accreditation options.*** In addition to either choosing the current long term care accreditation survey or opting out of the long term care survey, JCAHO now offers a third choice: Medicare/Medicaid Certification Based Long Term Care accreditation. Organizations that choose this option will undergo a one-day, reduced-cost survey that focuses on a subset of LTC standards.

For more information about the 2003 survey process changes, check your accreditation manual and *Joint Commission Perspectives*. The Source

Spotlight on Success



Pain Assessment and Management: A Team Solution

Vital Statistics

Facility Facts

HealthSouth North East Florida Region comprises three ambulatory care facilities: HealthSouth Melbourne Surgery Center; HealthSouth Medical Partners Surgery Center, Jacksonville; and HealthSouth St. Augustine Surgery Center. These facilities perform a variety of outpatient surgeries. Each facility treats about 500 cases per month with a medical staff of close to 50.

Purpose of the Project

To ensure consistent and thorough pain management for surgery patients and increase patient satisfaction, the three facilities implemented a comprehensive program to educate staff, patients, and families on proper assessment and management of pain. The facilities developed a brochure that educates patients on pain management and provides a brief survey and pain scale yielding standardized assessment. Consistent methods of record documentation were introduced and results were tracked.

Outcomes

HealthSouth's brochure, *Understanding Pain Management,* provides a useful tool that allows patients and families to effectively communicate pain level; helps staff members educate patients on pain management as well as assess and monitor their need for pain management; assesses pain location, duration, and intensity; and provides a documentation form for use across the three facilities.

Pain, although a common part of patient experience, has the power to produce adverse physical and psychological effects that can severely affect an individual's recovery rate and quality of life. Every patient therefore has the right to appropriate assessment and management of pain.

JCAHO pain assessment and management standards prompted many ambulatory care organizations to review their processes, and in 2001 HealthSouth North East Florida Region embarked on a performance improvement (PI) project to address pain assessment and management for the surgical patients in its three ambulatory surgical facilities.

Located in Melbourne, Jacksonville, and St. Augustine, the three facilities managed their pain assessment, education, and documentation differently and inconsistently in the preoperative and postoperative areas, according to Lee Rocque, Administrator for HealthSouth Melbourne Surgery Center.

To better understand the variation among their procedures, the three facilities together studied corporatewide patient satisfaction surveys regarding explanation of pain management. According to Rocque, the patient satisfaction survey revealed that the three facilities had received below-average ratings in the area of pain management education.

In response to those findings, the facilities created a PI grid and discovered that developing a PI process to address pain assessment and management needed to be a top priority.

Developing a Solution

Before diving into the PI process, HealthSouth assembled a work team consisting of nurses and physicians to spearhead the project. The team's first order of business was to perform a root cause analysis (RCA), which revealed

- an inability of patients and families to effectively communicate pain level;
- an absence of appropriate tools to educate patients on pain management and assess and monitor their need for pain management;
- limited staff knowledge regarding new JCAHO standards and changes in the pain assessment process;
- a lack of consistent pain scale and documentation forms across the three facilities; and
- a need for periodic and consistent re-evaluation of patient pain.

With the results of the RCA in hand, the team began researching JCAHO standards regarding pain management to ensure that any new program would comply with relevant standards.

While studying the standards, the team also gathered input from facility staff and reviewed pain management forms from similar ambulatory care facilities across the country. With that information in mind, the HealthSouth group created a regionwide brochure for staff to appropriately teach patients and families how pain is assessed. Once developed, the brochure was presented to the medical executive committees of all three facilities for approval.

This educational tool, designed to ensure that patients receive appropriate postoperative pain measures, includes a definition of pain, information about the rights of patients regarding pain management, questions for patients to ask before and after surgery, and the types of pain management options available. It also offers a brief pain management survey (see the sidebar) and a pain scale to help patients consistently

communicate their degree of pain. To overcome any potential language, age, or cultural barriers, the pain scale includes both words and faces to help patients identify their level of pain.

The facilities discovered that patients and staff members had different definitions and experiences with pain. In some cases, surgery may be a patient's first experience with significant pain. To teach patients how to use the pain scale, the staff relates the scale to a person's previous experiences with pain. For example, nurses are instructed to ask, "What's the worst pain you've experienced to date? How does your current pain compare with that pain?" The patient then is encouraged to communicate the level of pain using the pain scale.

Determining Effectiveness

As a result of the PI project and brochure, HealthSouth noted performance improvements in several areas:

- ***Communication and treatment.*** Rocque says staff responded positively to the pain management tool. Nurses, in particular, indicated that the brochure not only helped them communicate more effectively with patients, but also helped them better identify and address their pain needs. As an added benefit, the tool helped pinpoint any ancillary physical problems. For example, Rocque says, a person scheduled for eye surgery might complain of knee pain. Although not directly related to the eye, the knee pain might influence how the patient is positioned during surgery. It therefore is important to identify all types of patient pain, not just pain related directly to impending surgery.
- ***Patient satisfaction.*** Before the PI project, the average level of patient satisfaction with the explanation of pain management for the three facilities was slightly below the corporate average of 85%. One year after the introduction of the brochure, the regional satisfaction average exceeded 90%.
- ***Consistency in documentation.*** The facilities also reviewed random medical records to ensure that pain assessment and education were documented. According to Rocque, before the PI project, only one of the three facilities in the region consistently documented preoperative pain assessment and education. One year later, all three organizations were consistently documenting pain assessment and education.

You can access another *free* **sample pain assessment** and **management education brochure** online at www.jcrinc.com/periodicals. Just select *The Source* and select *Understanding Your Pain*.

Lessons to Share

The HealthSouth facilities learned that careful planning and thorough development were essential to successfully implement this PI process. The first step was analyzing the need for the process. The key is to determine which areas have the highest need for improvement and risk for patients. Using a standardized PI priority grid, the facilities were able to objectively determine the importance of the project. By thoroughly tracking results of the project, the facilities are able to monitor program progress and highlight any need for further improvement.

Staff involvement also is necessary for program success. No PI project can be implemented successfully without proper education, support, and compliance by staff. To ensure consistency of use, in-services were provided to educate staff members about JCAHO's pain management standards and the information in the new brochure. Brochures also were provided to all physician offices servicing the three HealthSouth facilities in the region, which were encouraged to provide patients with the brochures before surgery.

Rocque reports that the HealthSouth facilities will continue improving their pain management program in the future. The three facilities plan to study different patient learning styles in order to develop other educational tools that address a variety of needs, including a brochure for non-English-speaking patients. The Source

Pain Management Survey

Initial pain assessment and evaluation
Are you having pain related to your scheduled procedure? Yes____ No____
Where is your pain located? _____
Duration of pain _____
Intensity of pain _____

Using the pain scale
Does the pain radiate? Yes____ No____
If so, where? _____
When was the pain most intense in the past 24 hours? _____
Are you currently taking medication to manage your pain? Yes____ No____
If so, what are you taking, and is it effective? _____
Does the pain interfere with your activities of daily living? Yes____ No____
List specific examples, i.e., sleeping or eating, bending _____
List methods used at home to relieve your pain. _____

In addition to the survey, HealthSouth's brochure includes a pain scale, general information about pain and pain relief rights, questions to ask pre- and postsurgery, and pain management techniques.

Source: HealthSouth North East Florida Region. Used with permission.

Table 1. Rolling Out Shared Visions—New Pathways

Component	Target Date	Settings Affected						
		AMB	BHC	HCN	OME	HAP	LAB	LTC
Revised standards	January 2004	x	x		x	x	x	x
Self-assessment	Distribution in fourth quarter of 2003 for organizations due for survey in or after July 2005	x	x		x	x		x
Priority Focus Process	January 2004	x	x		x	x	x	x
Revised survey process	January 2004	x	x	x	x	x	x	x

AMB=Ambulatory Care; BHC=Behavioral Health Care; HCN=Health Care Network; OME=Home Care; HAP=Hospital; LAB=Laboratory; and LTC=Long Term Care

Shared Visions—New Pathways

Continued from Page 2

imply that the critical focus areas for an organization are deficient or out of compliance in any way. In essence, the PFP customizes the survey process to each organization as opposed to following a standards compliance checklist.

Fine-tuning the Survey Process

Rather than producing activities created just for survey, the new survey agenda runs tandem with an organization's normal systems. Using a tracer methodology, surveyors assess an organization's systems of providing care and services using actual care recipients or patients as the basis for assessing standards compliance. Making use of pre-survey data and self-assessment information, fewer formal interviews, and more attention to actual individuals receiving care will customize the survey process to the settings, the services, and the populations served.

The only formal meetings include opening and closing conferences and a leadership interview. The remaining time will be devoted to

- validating that the Corrective Action Plan generated from the self-assessment has been implemented;
- visiting care and service areas using the tracer methodology, which works with the PFP to track patients through the organization; and
- interactive evaluation, education, and guidance on high-priority safety and quality of care issues.

The hospitals that participated in JCAHO pilot tests indicated that the tracer methodology digs deeper into the overall process. The new process, pilot organizations said, should raise patient care to another level. One health care professional who followed a surveyor through a patient case stated that she favored the tracer approach, which focused on "coordination, process, and continuum of care."

Overall, the pilot test participants who accompanied the surveyors indicated that the new survey process greatly clarified what the surveyors were looking at, why they were asking certain questions, and what information they were trying to elicit from staff.

Direct care staff members can expect surveyors to talk with them about care and services actually provided. Their response will be interpreted in terms of standards compliance. For example, a surveyor might initiate the following discussion with care staff:

"Mrs. Smith's chart indicates that she is on a special diet. How was her nutritional assessment done? How did staff notify nutritional services and the pharmacy of her needs and precautions? What did you teach Mrs. Smith about her diet and any relationship to her medications? She's on a lot of meds. Let's go to the pharmacy and discuss their involvement with her case."

As surveyors examine multiple cases, performance issue trends may be identified. The surveyors will work with organizations to address these trends, provide on-site education and guidance on ways to improve, and offer successful practices from other organizations.

The future of JCAHO's new accreditation process is in full swing, and as it continues to evolve, *The Source* will keep you up-to-date with a regular feature devoted specifically to Shared Visions—New Pathways. In the meantime, if you have specific questions, please contact **sharedvisions@jcaho.org.** The Source

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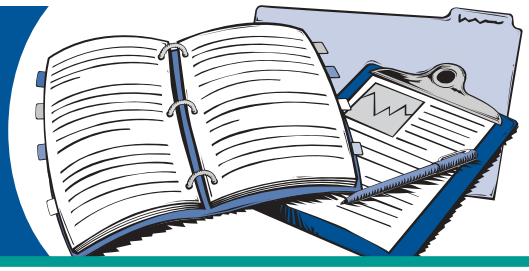
The Expert Connection



Credentialing and Privileging: Five Steps for Meeting JCAHO Standards

Credentialing and privileging licensed independent practitioners (LIPs) can be one of the most frustrating and time-consuming challenges facing health care organizations. As a JCAHO surveyor, Samuel S. Fager, MD, MBA, JD, has pinpointed a number of stumbling blocks that can keep organizations from getting the job done effectively and efficiently. Addressing these, he says, often is a matter of taking a few basic steps.

1. Make sure the process is the same in reality as on paper.
JCAHO wants to see that the way an organization appoints, reappoints, and extends clinical privileges to individuals is clearly spelled out in medical staff documents—and that those processes are, in fact, the ones used. Often, Fager says, organizations will change a process without updating it on paper.

TIP He recommends that the people closest to the actual processes create flow diagrams, which can then be compared with the documents. Where there's a discrepancy, "there should be some thinking about which needs to be changed in order to best meet the needs of the organization and JCAHO and state regulatory standards," Fager adds.

2. Use teamwork and timing to expedite the reappointment process.
Many organizations struggle with the two-year reappointment deadline.

TIP The key to making it, according to Fager, is to solicit the cooperation of individual practitioners in processing their paperwork—and to start that process early enough; six months out is not too soon. He also suggests that organizations:

- Consider dividing up the work throughout the year.
- Schedule committee meetings far enough in advance to accommodate the approval process.
- Use expedited credentialing when available. For example, hospital and long term care standards allow for a subcommittee of the board to review and approve "clean" applications.
- Have the governing body approve effective periods in advance. For example, October effective periods are approved at the September board meeting. The effective date does not change to match the board meeting date and would not be exceeded if the board meeting date changes.

3. Decide whether the credentialing and privileging processes or human resources (HR) processes should be used for allied health professionals (AHPs)—and stick to it.
If AHPs are allowed by state law and the organization to practice independently, they must be credentialed and privileged.

Where state law and organization bylaws both require AHPs to practice dependently, the Joint Commission offers organizations two choices: Credential and privilege these individuals through the credentialing process, or turn them over to HR. Either is fine, as long as the organization can demonstrate to JCAHO what process it is using and why, and that it is being applied consistently.

4. Develop a process for reappraisal of individuals in one- or two-person departments or specialties.
The Joint Commission does not prescribe how ongoing performance reviews should be conducted before reappointment—through observation, medical record review, or analysis of performance data, for example—as long as it gets done in an appropriate manner.

TIP Instead, Fager encourages organizations in this position to work out cooperative arrangements with other facilities—such as a nearby medical school that is not in direct competition—or use an independent observer from outside the organization.

5. Decide which data will form the basis for a decision to reappoint.
How can organizations determine if an individual should continue to have privileges if that person seldom or never admits anyone? JCAHO prefers to see individual performance improvement data in the context of similar aggregate data, something that can be hard to obtain for ambulatory care. The answer, says Fager, lies in the two other options JCAHO standards set out for demonstrating competency: letters of recommendation from peers, and recommendations from department chairs or section chiefs.

TIP The more specific the criteria, the better. Instead of asking for "general comments," Fager encourages organizations to send out letter-of-recommendation forms that feature a checklist of specific criteria, such as ethical standards, clinical competence, continuing medical education, and health conditions.

Together, says Fager, these steps can go a long way to help organizations successfully meet JCAHO standards for credentialing and privileging. TheSource

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